



## 2008 DEPENDENT DROP FORM

### Give this form to your Insurance Coordinator

This form must be used for any qualifying event (QE) that allows you to drop dependents from your plan. (You must complete an Enrollment Application to request other coverage election changes such as electing new coverage, option changes, new waiver or to cease a cross reference plan)

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Applicant's SSN

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Retiree's SSN (if applicable)

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Company Number

Print Name (First, MI, Last) \_\_\_\_\_

To be eligible to drop a dependent from your health insurance plan, you must certify that you have experienced the QE as listed here.

By signing this form you are also certifying that you are not under any administrative order to cover the dependent(s) on your health insurance plan.

**NOTE: DEPENDENTS WILL BE DROPPED FROM YOUR PLAN AT THE END OF THE MONTH OF THE SIGNATURE DATE ON THIS FORM.**

#### Exceptions:

- ❖ *Death: dependent will be dropped effective the date of death.*
- ❖ *Ineligible Dependents: ineligible dependents will be dropped from the plan at the end of the month in which they become ineligible.*

#### Qualifying Events: (Check one)

- ☐ Divorce\*/Legal Separation\*/ Annulment\*
- ☐ Legal Guardianship/Admin Order/Court Order\* +
- ☐ Spouse/Dependent/Retiree's Death
- ☐ Dependent child becomes ineligible
- ☐ Spouse/Dependent gains employer-sponsored Group Coverage\*
- ☐ Sp/Dependent ends LWOP\* (resumes coverage)
- ☐ Sp/Dep becomes eligible for Medicare\*
- ☐ Sp/Dep becomes eligible for Medicaid\*
- ☐ Sp/Retiree has a different open enrollment period\*+
- ☐ Dependent Care Significant cost increase
- ☐ Other \_\_\_\_\_

Qualifying Event Date (mm/dd/yy): \_\_\_\_\_

Note: SP = Spouse DEP = Dependent

\* Supporting documentation required

+Refer to QE chart for rules/effective dates at [www.KEHP.ky.gov](http://www.KEHP.ky.gov)

**PRINT the following information for each dependent to be dropped. If dropping self, you must complete an Enrollment Application.**

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth	Rel. Code **
		M F		
		M F		
		M F		
		M F		

\*\* Rel. Code: SP = Spouse / CH = Child / CO = Court Ordered Dependent / DD = Disabled Dependent

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Applicant Signature

Date

Insurance Coordinator Signature

Date

Signatures are required below if changes to an existing cross-reference plan are being requested

Spouse Signature

Date

Spouse Insurance Coordinator Signature

Date